Name: _____ DOB: ___/___ /___ Medicaid ID: _____ Record #: _____
Date of Initial Plan: ___/___/___

_____'s PERSON-CENTERED PLAN

Person Responsible for Plan: _____

(State Funding Only)
Service Authorization By: _____

Authorization Date: ____/____/____

Person's Preferred Name: _____

Address: _____

City/State/Zip: _____

Home Phone: (____)-_____-_____

Work Phone: (____)-_____-_____ ext.: _____

TYPE OF PLAN: (check all that apply)

☐ Initial Person-Centered Plan
☐ Update/Revision Date: ___/___ /___
☐ Update/Revision including annual review of Medical Necessity Date: ___/___ /___

Local Management Entity: _____

Primary Care Physician: _____

Medicaid County (If applicable): _____

Medicare/Insurance: _____

CONTACT PERSON(S)

Emergency Contact or Next of Kin: _____

Relationship to Person: _____

Address: _____

City/State/Zip: _____

Home Phone: (____)-_____-_____

Work Phone: (____)-_____-_____ ext. _____

Legally Responsible Person's Name: _____

Telephone Number: (____)-_____-_____

If Appointed: **(Attach copy of supporting documents)** _____

Date of Legal Document: ___/___ /___

Clinical Home Agency: _____

First Responder Contact: _____

Work Phone Number: (____)-_____-_____ ext. _____

Cell Phone Number: (____)-_____-_____

Pager: (____)-_____-_____

Name: ______________________________ DOB: ___/___ /___ Medicaid ID: __________________ Record #: ____________
Date of Initial Plan: ___/___/___

PARTICIPANTS INVOLVED IN INITIAL PLAN DEVELOPMENT

Name: ____ Relation/Agency: ___________________________________ **Role:** ☐ Facilitator of PCP meetings ☐ Participated in @ least 1 planning meeting ☐ Provided written input ☐ Telephone participation ☐ Invited, but no participation ☐ Other:	Name: ____ Relation/Agency: ___________________________________ **Role:** ☐ Facilitator of PCP meetings ☐ Participated in @ least 1 planning meeting ☐ Provided written input ☐ Telephone participation ☐ Invited, but no participation ☐ Other:
Name: ____ Relation/Agency: ___________________________________ **Role:** ☐ Facilitator of PCP meetings ☐ Participated in @ least 1 planning meeting ☐ Provided written input ☐ Telephone participation ☐ Invited, but no participation ☐ Other:	Name: ____ Relation/Agency: ___________________________________ **Role:** ☐ Facilitator of PCP meetings ☐ Participated in @ least 1 planning meeting ☐ Provided written input ☐ Telephone participation ☐ Invited, but no participation ☐ Other:
Name: ____ Relation/Agency: ___________________________________ **Role:** ☐ Facilitator of PCP meetings ☐ Participated in @ least 1 planning meeting ☐ Provided written input ☐ Telephone participation ☐ Invited, but no participation ☐ Other:	Name: ____ Relation/Agency: ___________________________________ **Role:** ☐ Facilitator of PCP meetings ☐ Participated in @ least 1 planning meeting ☐ Provided written input ☐ Telephone participation ☐ Invited, but no participation ☐ Other:

Other individuals that I or my family would like to be part of this planning process now or in the future.

Name: _____ DOB: ___/___ /___ Medicaid ID: _____ Record #: _____
Date of Initial Plan: ___/___/___

Personal Interview

Date(s) of Interview(s): ___/___/___

(This section must include what is important TO the person to whom this plan belongs. Also include issues related to the person's environment, culture, ethnicity and race as appropriate.) *ADD/REVISE INFORMATION WHENEVER NEW THINGS ARE LEARNED ABOUT THIS PERSON. SIGN NAME (NO INITIALS) AND DATE (NEXT TO THE CHANGE), EACH TIME THIS SECTION IS ADDED TO OR REVISED.*

What has happened in my life this past year? (Include exciting, fun things as well as challenges and concerns):

Long Term Goals: (What are the things I want to accomplish in the next year? What are my hopes/dreams for the future?)

Strengths: (What am I good at doing? What do people admire about me? What are my talents/gifts?)

Preferences: What is important **TO** me: (What are the people/activities/things/places that matter to me in everyday life? What I don't want in my life?)

Needs: (What would I change about my life? What is not working in my life? What do I need in order to be an active part of my community? What do I need to be healthy and safe?)

Supports: What is important **TO** me? (What do others need to know or do to support me best in relationships, in things I like to do, in work or school and ways to stay healthy and safe?)

Name: _____ DOB: ___/___ /___ Medicaid ID: _____ Record #: _____
Date of Initial Plan: ___/___/___

Family/Legally Responsible Person/Informal Supports Interview

(This section must include what is important **TO** the person and what is important **FOR** the person from the interviewee's perspective. Also include issues related to the person's environment, culture, ethnicity and race as appropriate.) *ADD/REVISE INFORMATION WHENEVER NEW THINGS ARE LEARNED ABOUT THIS PERSON. SIGN NAME (NO INITIALS) AND DATE (NEXT TO THE CHANGE), EACH TIME THIS SECTION IS ADDED TO OR REVISED.*

What has happened in this person's life this past year? (Include exciting, fun things as well as challenges and concerns):

Long Term Goals: (What are the things the person wants to accomplish in the next year? What are this person's hopes/dreams for the future?)

Strengths: (What is this person good at doing? What do people admire about this person? What are this person's talents/gifts?)

Preferences: What is important **TO** this person: (What are the people/activities/things/places that matter to this person in everyday life? What does the person not want in his/her life?)

Needs: (What would this person change about his/her life? What is not working in this person's life? What does this person need in order to be an active part of the community? What does he/she need to be healthy and safe?)

Supports: What is important **FOR** this person? (What do others need to know or do to support this person best in relationships, in things he/she likes to do, in work or school and ways to stay healthy and safe?)

Name: _____ DOB: ___/___ /___ Medicaid ID: _____ Record #: _____
Date of Initial Plan: ___/___/___

Service/Support Providers Interview

(This section must include what is important **TO** the person and what is important **FOR** the person from the interviewee's perspective. Also include issues related to the person's environment, culture, ethnicity and race as appropriate.) *ADD/REVISE INFORMATION WHENEVER NEW THINGS ARE LEARNED ABOUT THIS PERSON. SIGN NAME (NO INITIALS) AND DATE (NEXT TO THE CHANGE), EACH TIME THIS SECTION IS ADDED TO OR REVISED.*

What has happened in this person's life this past year? (Include exciting, fun things as well as challenges and concerns):

Long Term Goals: (What are the things the person wants to accomplish in the next year? What are this person's hopes/dreams for the future?)

Strengths: (What is this person good at doing? What do people admire about this person? What are this person's talents/gifts?)

Preferences: What is important **TO** this person: (What are the people/activities/things/places that matter to this person in everyday life? What does the person not want in this person's life?)

Needs: (What would this person change about his/her life? What is not working in this person's life? What does this person need in order to be an active part of the community? What does he/she need to be healthy and safe?)

Supports: What is important **FOR** this person? (What do others need to know or do to support this person best in relationships, in things he/she likes to do, in work or school and ways to stay healthy and safe?)

Name: _____ DOB: ___/___ /___ Medicaid ID: _____ Record #: _____
Date of Initial Plan: ___/___/___

SUMMARY OF ASSESSMENTS/OBSERVATIONS

ASSESSMENTS COMPLETED (Include medical/dental if applicable)	ISSUES TO ADDRESS	LAST DATE COMPLETED	APPROXIMATE DUE DATE
Diagnostic Assessment &/or Evaluation (90801)		/ /	/ /
NC TOPPS (MH/SA only)		/ /	/ /
		/ /	/ /
		/ /	/ /

ADDITIONAL ASSESSMENTS RECOMMENDED	ISSUES TO ADDRESS	APPROXIMATE DUE DATE	DATE COMPLETED
		/ /	/ /
		/ /	/ /
		/ /	/ /

	(DSM* Code)	(Diagnosis)	(Diagnosis Date)
Axis I			/ /
Axis II			/ /
Axis III			/ /
Axis IV			/ /
Axis V			/ /

(*The Diagnostic & Statistical Manual of Mental Health Disorders IV-TR, 2000 organizes psychiatric diagnosis on 5 axes. They are listed below):
Axis I: Major Mental Disorders: Developmental Disorders and Learning Disabilities
Axis II: Personality Conditions and Mental Retardation
Axis III: Any Non-Psychiatric Medical Condition
Axis IV: Social Functioning and how symptoms affect the person
Axis V: Global Assessment of Functioning (GAF) based on a scale of 100-0 for adults and/or the Children's Global Assessment Scale, also a 100-point scale

Recommendations for Services/Support/Treatment From Assessments	Frequency:	Duration:	Target Date:	State/Medicaid/ Health Choice
1.			/ /	
2.			/ /	
3.			/ /	

Symptoms/Observations of this Person:
1.
2.
3.
4.

Name: _____ DOB: ___/___ /___ Medicaid ID: _____ Record #: _____
Date of Initial Plan: ___/___/___

ACTION PLAN

Long Range Outcome: (Ensure that this is an outcome desired by the individual, and not a goal belonging to others.)

Where am I now in relation to this outcome?

SYMPTOM/OBSERVATION #:

Short Range Goal (Taken from Preferences & Supports Sections ("What's important TO & FOR me")	**Support/Intervention to Reach Goal (Taken from Supports Sections)**	**Who will Provide Support/Intervention/ Service?**	**Support/Service & frequency**

Target Date (Not to exceed 12 months.)	**Reviewed Date**	**Status Code**	**Justification for Continuation/Discontinuation of Goal**
/ /	/ /		
/ /	/ /		
/ /	/ /		

Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued

SYMPTOM/OBSERVATION #:

Short Range Goal (Taken from Preferences & Supports Sections ("What's important TO & FOR me")	**Support/Intervention to Reach Goal (Taken from Supports Sections)**	**Who will Provide Support/Intervention/ Service?**	**Support/Service & frequency**

Target Date (Not to exceed 12 months.)	**Reviewed Date**	**Status Code**	**Justification for Continuation/Discontinuation of Goal**
/ /	/ /		
/ /	/ /		
/ /	/ /		

Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued

Name: _____ DOB: ___/___ /___ Medicaid ID: _____ Record #: _____
Date of Initial Plan: ___/___/___

ACTION PLAN CONTINUATION

Long Range Outcome: (Ensure that this is an outcome desired by the individual, and not a goal belonging to others.)

Where am I now in relation to this outcome?

SYMPTOM/OBSERVATION #:

Short Range Goal (Taken from Preferences & Supports Sections ("What's important TO & FOR me")	**Support/Intervention to Reach Goal (Taken from Supports Sections)**	**Who will Provide Support/Intervention/ Service?**	**Support/Service & frequency**

Target Date (Not to exceed 12 months.)	**Reviewed Date**	**Status Code**	**Justification for Continuation/Discontinuation of Goal**
/ /	/ /		
/ /	/ /		
/ /	/ /		

Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued

SYMPTOM/OBSERVATION #:

Short Range Goal (Taken from Preferences & Supports Sections ("What's important TO & FOR me")	**Support/Intervention to Reach Goal (Taken from Supports Sections)**	**Who will Provide Support/Intervention/ Service?**	**Support/Service**

Target Date (Not to exceed 12 months.)	**Reviewed Date**	**Status Code**	**Justification for Continuation/Discontinuation of Goal**
/ /	/ /		
/ /	/ /		
/ /	/ /		

Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued

Name: _____ DOB: ___/___ /___ Medicaid ID: _____ Record #: _____
Date of Initial Plan: ___/___/___

CRISIS PREVENTION/CRISIS RESPONSE

(Use this form and/or attach your crisis plan.)

Symptoms/behaviors that may trigger the onset of a crisis (include lessons learned from previous crisis events):

Crisis prevention and early intervention strategies (List everything that can be done to help this person avoid a crisis):

Strategies for crisis response and stabilization (Focus first on natural and community supports. Begin with least restrictive steps. Include process for obtaining back-up in case of emergency and planning for use of respite, if an option. List everything you know that has worked to help this person to become stable):

Specific recommendations if person arrives at the Crisis and Assessment Service:

All Current Medications (* Update and revise list of medications anytime there is a change)	**Dose:**	**Frequency:**	**Reason for Change:**	**Date**
				/ /
				/ /
				/ /
				/ /

After the crisis, identify strategies for determining what worked and what did not work, and make changes to the plan:

Name: _____ DOB: ___/___ /___ Medicaid ID: _____ Record #: _____
Date of Initial Plan: ___/___/___

CRISIS PREVENTION/CRISIS RESPONSE (CONTINUATION)

Contact List (Include names as applicable, relationship and direct phone numbers or extension.)

First Responder: _____ Telephone #: (____)-_____-_____ Consent/Release of Information: ☐ Yes ☐ No

Legally Responsible Person: _____ Telephone #: (____)-_____-_____Consent/Release of Information: ☐ Yes ☐ No
(If applicable)

Natural/Community Supports:

Name: _____ Telephone #: (____)-_____-_____ Consent/Release of Information: ☐ Yes ☐ No

Name: _____ Telephone #: (____)-_____-_____ Consent/Release of Information: ☐ Yes ☐ No

Professional Supports:

Name: _____ Telephone #: (____)-_____-_____ Consent/Release of Information: ☐ Yes ☐ No

Primary Care Physician: _____ Telephone #: (____)-_____-_____
Consent/Release of Information: ☐ Yes ☐ No

Preferred Psychiatric Inpatient /Respite Provider: _____ Telephone #: (____)-_____-_____
Consent/Release of Information: ☐ Yes ☐ No

Other Professional Supports:

Name: _____ Telephone #: (____)-_____-_____ Consent/Release of Information: ☐ Yes ☐ No

Name: _____ Telephone #: (____)-_____-_____ Consent/Release of Information: ☐ Yes ☐ No

Advanced Directives: (Advance Directives allow you to plan ahead for care in the event that there are times that you are unable to speak for yourself).

☐ Yes ☐ No I have a Living Will. ☐ Yes ☐ No I would like one.

☐ Yes ☐ No I have a Health Care Power of Attorney. ☐ Yes ☐ No I would like one.

☐ Yes ☐ No I have an Advanced Instruction for Mental Health Treatment. ☐ Yes ☐ No I would like one.

Crisis Plan Distribution List (List contact information):

Name: _____ DOB: ___/___ /___ Medicaid ID: _____ Record #: _____
Date of Initial Plan: ___/___/___

Comments or Concerns on Plan by the person whose plan this is and/or the legally responsible person:

Steps to address concerns:

Signatures

REQUIRED for Medicaid funded services. RECOMMENDED for State funded services.

My signature below confirms that medical necessity for services requested is present, and constitutes the Service Order(s):

Signature: _____ Date: ___/___ /___

(Name/Title Required. Must be licensed physician, licensed psychologist, licensed physician's assistant or licensed family nurse practitioner.)

Annual review of medical necessity and re-ordering of services is due on or before: ___/___ /___

Person Receiving Services:

- I confirm and agree with my involvement in the development of this person-centered plan. My signature means that I agree with the services/supports to be provided.
- I understand that I have the choice of service providers and may change service providers at any time, by contacting the person responsible for my plan.

Signature:_____ Date: ___/___ /___

(Required when person is his/her own legally responsible person)

- **The following signatures confirm the involvement of individuals in the development of this person-centered plan. All signatures indicate agreement with the services/supports to be provided.**
- **For state-funded services, if the first signature box on this page is not completed, the signature of *the Person Responsible for the Plan* in this box constitutes the Service Order. Complete the Annual Review date if this is the Service Order.**

Legally Responsible Person Signature:_____ Date: ___/___ /___

(Required, if other than the individual)

Person Responsible for the Plan Signature: _____ Date: ___/___ /___
(Required)

Annual Review of medical necessity and re-ordering of State-funded services is due on or before: ___/___ /___

Other Team Member Signature: _____ Date: ___/___ /___

Other Team Member Signature: _____ Date: ___/___ /___

Name: _____ DOB: ___/___ /___ Medicaid ID: _____ Record #: _____
Date of Initial Plan: ___/___/___

☐ **Plan Update/Revision - Date:** ___/___ /___
☐ **Annual Review of Medical Necessity - Date:** ___/___ /___

(Continue to address what is important **TO** and **FOR** the person within all updates/revisions. Include issues relate to the person's environment, culture, ethnicity, and race as appropriate)**.**

Long Range Outcome:

Where am I now in relation to this outcome?

SYMPTOM/OBSERVATION #:

Short Range Goal (Taken from Preferences & Supports Sections ("What's important TO & FOR me")	**Support/Intervention to Reach Goal (Taken from Supports Sections)**	**Who will Provide Support/Intervention/ Service?**	**Support/Service**

Target Date (Not to exceed 12 months.)	**Reviewed Date**	**Status Code**	**Justification for Continuation/Discontinuation of Goal**
/ /	/ /		
/ /	/ /		
/ /	/ /		

Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued

Provide signatures on the next page

Name: _____ DOB: ___/___ /___ Medicaid ID: _____ Record #: _____
Date of Initial Plan: ___/___/___

☐ **Plan Update/Revision - Date:** ___/___/___ *[continued]*
☐ **Annual Review of Medical Necessity – Date:** ___/___/___ *[continued]*

Signatures

REQUIRED for Medicaid funded services. RECOMMENDED for State funded services.

If this Update/Revision includes a NEW service(s) and/or is the annual review of medical necessity, my signature below confirms that medical necessity for the service(s) requested is present and constitutes the Service Order(s):

Signature: _____ Date: ___/___ /___

(Name/Title Required. Must be licensed physician, licensed psychologist, licensed physician's assistant or licensed family nurse practitioner.)

Annual Review of medical necessity is due on or before: ___/___ /___

Person Receiving Services:

- I confirm and agree with my involvement in the development of this update/revision to my person-centered plan. My signature means that I agree with the services/supports to be provided.
- I understand that I have the choice of service providers and may change service providers at any time by contacting the person responsible for my plan.

Signature:_____ Date: ___/___ /___
(Required when person is his/her own legally responsible person)

- **The following signatures confirm the involvement of individuals in the development of this update/revision to the person-centered plan. All signatures indicate agreement with the services/supports to be provided.**
- **For State-Funded services, if the first signature box on this page is not completed AND this Update/Revision includes a NEW service(s) and/or is the annual review of medical necessity, the signature of the *Person Responsible for the Plan* in this box constitutes the Service Order. Complete the Annual Review date if this is the Service Order.**

Legally Responsible Person Signature:_____ Date: ___/___ /___
(Required, if other than the individual)

Person Responsible for the Plan Signature: _____ Date: ___/___ /___
(Required)

Annual Review of medical necessity and re-ordering of State-funded services is due on or before: ___/___ /___

Other Team Member Signature: _____ Date: ___/___ /___

Other Team Member Signature: _____ Date: ___/___ /___